Screening

Chlamydia screening and sexual health

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Are we failing heterosexual men?

Six years after publication of the first expert advisory recommendations[1] and subsequent calls for the introduction of a national chlamydia screening programme, tentative steps are at last being made towards its implementation. Much of the baseline research required to support the evidence base for programme development has been undertaken or is nearing completion. Other initiatives (for example, the PHLS chlamydia incidence and reinfection study) are just beginning. To date, research and planning have largely centred on women, justified on the basis that such a strategy is evidence based, cost effective, and pragmatic.[2] However, critics of the proposed policy have suggested that decisions about the inclusion or exclusion of men from any screening programme should be based on epidemiological evidence and that a useful strategy would be to collect such data *before* making recommendations about the future shape of any screening programme.[3] Failure to more fully include men in the formative research and development work has resulted in a missed opportunity to gather the epidemiological data needed to make evidence based decisions about men's participation. However, such evidence is now emerging. Results of the Department of Health funded chlamydia screening pilots in Portsmouth and the Wirral found a prevalence of up to 9% among young men attending youth centres and nearly twice this among men attending GUM clinics.[4] More recently, a community recruited probability sample survey of sexual attitudes and lifestyles of British adults aged 18–44, found more men (1 in 45) than women (1 in 66) were identified as *C trachomatis* positive through ligase chain reaction (LCR) testing of urine.[5] The study's highest age specific prevalence (3.0%) was found among men 25–34 years of age. Both studies, along with STI surveillance reports, confirm the substantial disease prevalence among community and GUM clinic populations of men and the marked heterogeneity in the prevalent pool of undiagnosed infection in the population. We now have evidence which questions the wisdom of the targeting of sexual health screening by sex for chlamydia as men have an equal, or even greater, risk of infection than women.

It is therefore timely to again question a central plank of the programme, notably the failure to screen men, while opportunistically screening sexually active women under 25 (and women over 25 with a new sexual partner, or two or more partners in the past year) in family planning clinics and general practice. This approach has already been criticised, mainly from the perspective of the negative social and psychological consequences for women,[6 7] as well as its impact on effective STI prevention.[8] In the absence of good epidemiological data on men, many argued that to screen and treat one sex and not another would be ineffective in terms of eradication or control. This was last attempted in the 1860s through the Contagious Disease Acts, which mandated that women in English ports and garrison towns could be subjected to enforced sexual health screening, while their sexual partners (sailors and soldiers) were treated only on presentation with symptoms. However, it was the availability of effective antimicrobial therapy, screening and treatment for symptomatic individuals and proactive partner notification, freely administered to both men and women, that led to the substantial declines in syphilis rates in the 1950s.[9]

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It has been argued that the failure to address the sexual health needs of heterosexual men is a human rights issue,[10] but even from the perspective of women's health, the logic of reducing the transmission of sexual pathogens by screening and treating men is persuasive. As currently envisioned, chlamydia screening is essentially a secondary prevention strategy for women as it seeks to identify and treat undiagnosed prevalent infection and its attendant complications. Primary prevention in women, in which the risk of acquiring the infection is reduced, is best achieved by reducing disease prevalence in men.[8] The contribution of heterosexual men to STI transmission appears to be overlooked continually, not only the CMO's report,[1] but also in the proposed sexual health strategy for England, which fails to identify any means by which heterosexual men can be targeted with sexual health services.[11] The proposed model of three levels of service provision in the strategy suggests that women are screened under level one, but refers to "invasive" STI testing for men only as a subset of level two service (the screening of women is not described as invasive). Once again, chlamydia screening is largely concerned with women, with proposals to introduce screening among those seeking termination of pregnancy and women attending for their first cervical smear. The strategy also perpetuates the invisibility of heterosexual men as a category: there is not one reference to this group in the entire report. "Young men" are mentioned, but this is in relation to interventions to encourage them to use sexual health services. Although the strategy aims to be evidence based, this does not accord with the epidemiology of bacterial STIs: the highest incidence of diagnosed chlamydia is in men aged 25–34, twice the rate of that of younger men aged 16–24.[12]

In general then, heterosexual men appear to be getting a raw deal when it comes to STIs.[13] More specifically, they are largely ignored in the campaign to reduce the incidence of chlamydia. The CMO's report recognised the difficulty of accessing heterosexual men, and there are well established sex differences in health seeking behaviour, with men less likely to use primary healthcare services than women.[14 15] There is a dearth of literature on the factors associated with men's reluctance to access sexual health services, and a recent systematic review identifies few successful sexual health interventions for heterosexual men.[16] However, this has been accepted as a reason not to screen, rather than as an opportunity to explore the probable complex factors involved in men's sexual health decision making.

On closer inspection, many of the assumptions informing the report are overstated. The difficulties of accessing healthy young men through general practice certainly warrant further investigation. The 1998 general practice survey found that 71% of men aged 18–44 had visited a general practitioners in the past year, which indicates that men are contactable through general practice.[17] Men made 80 000 visits to family planning clinics in 1999–2000.[11] Rates of GUM clinic attendance among men are equal to those for women.[5] If all of these men were offered screening for chlamydia, close on the heels of a publicity campaign, we would succeed in reaching a

large sexually active population of heterosexual men. This could be facilitated by increased use of urine testing in place of invasive techniques.

While research into the psychosocial factors involved in men's sexual health behaviour is in its infancy, studies have demonstrated that public understanding of the causes and consequences of chlamydia is very poor.[18] Men in particular need to be informed about what it is, how they could contract it, how its transmission is prevented, and the ease with which it is treated. Ideally this would involve a multimedia campaign of television, radio, poster, and magazine advertising for men and women. *Rugby World* was happy to take a Health Education Authority advertisement targeting bisexual men at the height of the AIDS scare in the early 1990s, so it and other "male interest" magazines should find chlamydia sexual health promotion for heterosexual men uncontroversial.

Finally, innovative outreach strategies may be needed to reach men who are less likely to use health services, or those in whom disease prevalence is particularly high. Ethnic variations in the prevalence of chlamydia and other bacterial STIs is well documented.[19 20] Culturally appropriate methods of population based screening, targeting both men and women in high incidence areas, should be piloted. The widespread availability of urine based nucleic acid amplification tests should mean that the hitherto unthinkable becomes increasingly possible: mobile clinics visiting further education colleges in London, Birmingham, and Manchester, as well as parking on street corners and in busy high streets. The same applies to targeting young men at football matches, in army camps, police and fire brigade training schools, and predominantly male work places. Occupational health screening remains an area requiring further assessment for feasibility. Men may be more likely to access an "information service" than a "helpline"; they may be relatively unconcerned about contraception, but very interested in their own fertility.

Yet perhaps the biggest problem is not the practicality of screening and treating heterosexual men for chlamydia, but the quite unintentionally sexist mindset that resists the notion of submitting men to the same sexual health surveillance as women. Healthcare professionals, with perhaps the honourable exception of genitourinary physicians, fear the reaction of men to suggested sexual health screening, and are particularly concerned not to cause them offence. We really need to move beyond this mindset if we are to accept that men's contribution to the transmission of STIs is a serious public health issue, and we should face up to our own fears about talking to, and providing comprehensive sexual health care for, heterosexual men. By including men we make them partners in the control and eradication of sexually transmitted infections—part of the solution, rather than the problem.

Key messages

- There is new evidence to suggest high rates of genital chlamydia infection in heterosexual men
- Current proposals for chlamydia screening do not include men. The recent sexual health strategy for England identifies no specific interventions for improved sexual health in heterosexual men. Both of these important policy documents perpetuate a situation in which men's sexual health needs are not addressed
- Opportunities do exist, particularly in primary care services, for the opportunistic screening of heterosexual men for *C trachomatis*
- Novel means of providing chlamydia screening and other sexual health services to men could be evaluated: in colleges, work, and leisure settings. Healthcare workers should confront their own concerns about offering these services to heterosexual men

CONTRIBUTORS

GH had the original idea for the editorial, wrote the first draft, and redrafted the final submission; BD and KF contributed further ideas for, and the writing of, each successive draft, including new information and references.

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